HOUSE BILL No. 1643

DIGEST OF INTRODUCED BILL

Citations Affected: IC 5-10-8.1; IC 27-8; IC 27-13-36.2.

Synopsis: Health insurance claim filing and payment. Specifies certain requirements for provider submission and payment of claims under state employee health benefit plans, accident and sickness insurance policies, and health maintenance organization contracts. Repeals the law requiring use of certain billing codes for health maintenance organization claims filing and payment.

C

Effective: July 1, 2005.

Ripley

January 19, 2005, read first time and referred to Committee on Insurance.

p

y



First Regular Session 114th General Assembly (2005)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in this style type, and deletions will appear in this style type.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or *this style type* reconciles conflicts between statutes enacted by the 2004 Regular Session of the General Assembly.

C

HOUSE BILL No. 1643

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

	,
V	7

SECTION 1. IC 5-10-8.1-2 IS AMENDED TO READ AS
FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 2. (a) As used in this
chapter, "clean claim" means a claim submitted by a provider for
payment under a health benefit plan that has no defect or impropriety,
including a lack of supporting documentation, or particular
circumstance requiring special treatment preventing payment.

- (b) The term does not include a:
 - (1) duplicate claim; or
 - (2) claim that:
 - (A) is submitted more than forty (40) days after the date of service; or
 - (B) does not comply with the electronic transaction standards and code sets governing the exchange of health information under the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d).

SECTION 2. IC 5-10-8.1-3.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS



8

9

10

11

12

13

14

15

16

1	[EFFECTIVE JULY 1, 2005]: Sec. 3.3. As used in this chapter,
2	"duplicate claim" means a duplicate of an original claim when the
3	duplicate is filed less than thirty (30) days after the filing of the
4	original claim.
5	SECTION 3. IC 5-10-8.1-5.5 IS ADDED TO THE INDIANA
6	CODE AS A NEW SECTION TO READ AS FOLLOWS
7	[EFFECTIVE JULY 1, 2005]: Sec. 5.5. As used in this chapter,
8	"supporting documentation" includes:
9	(1) verification of employer and covered individual coverage
10	under a health benefit plan;
11	(2) confirmation of premium payment;
12	(3) medical information concerning the covered individual
13	and health care services provided;
14	(4) information concerning:
15	(A) the responsibility of another third party payor to make
16	payment; or
17	(B) confirmation of the amount paid by another third
18	party payor; or
19	(5) information related to a diagnosis, a treatment, or the
20	provider's identification.
21	SECTION 4. IC 5-10-8.1-5.6 IS ADDED TO THE INDIANA
22	CODE AS A NEW SECTION TO READ AS FOLLOWS
23	[EFFECTIVE JULY 1, 2005]: Sec. 5.6. (a) An administrator and a
24	provider shall, in connection with all claims, use the medical data
25	code sets adopted by the United States Secretary of Health and
26	Human Services under the federal Health Insurance Portability
27	and Accountability Act of 1996 (42 U.S.C. 1320d).
28	(b) An administrator shall comply with the federal regulations
29	promulgated under Sections 503 and 505 of the federal Employee
30	Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.) in
31	paying a claim submitted by a provider for payment under a health
32	benefit plan.
33	(c) An administrator is not required to pay, and this chapter
34	does not apply to, a claim that is not filed in compliance with the
35	requirements for electronic transaction standards and code sets
36	that govern the exchange of health information under the federal
37	Health Insurance Portability and Accountability Act of 1996 (42
38	U.S.C. 1320d).
39	SECTION 5. IC 5-10-8.1-5.7 IS ADDED TO THE INDIANA
40	CODE AS A NEW SECTION TO READ AS FOLLOWS
41	[EFFECTIVE JULY 1, 2005]: Sec. 5.7. (a) A provider shall submit

a claim for payment under a health benefit plan to the



1	administrator:
2	(1) not more than forty-five (45) days after the date the claim
3	was incurred, or according to the contractual terms agreed to
4	between the administrator and provider; and
5	(2) according to the requirements for the electronic
6	transaction standards and code sets governing the exchange
7	of health information under the federal Health Insurance
8	Portability and Accountability Act of 1996 (42 U.S.C. 1320d).
9	(b) If an administrator requires supporting documentation to
10	process a claim, the provider shall submit the supporting
11	documentation not more than fifteen (15) days after receiving
12	notice that the supporting documentation is required.
13	(c) A provider may submit a written request for additional time
14	to submit a claim not more than forty-five (45) days after the claim
15	is incurred. If the administrator receives a request under this
16	subsection, the administrator shall provide an additional forty-five
17	(45) day period for the provider to submit the claim.
18	(d) If a provider submits a claim more than:
19	(1) forty-five (45) days and less than fifty-five (55) days after
20	the claim is incurred and has not requested additional time
21	under subsection (c), the administrator may deduct one-tenth
22	(1/10) of the total cost of the claim from the payment to the
23	provider for every day that the provider fails to submit the
24	claim after the period specified in subsection (a); or
25	(2) fifty-five (55) days after the date the claim is incurred, the
26	administrator may refuse to pay the claim.
27	(e) If a provider submits a claim more than forty-five (45) days
28	after the claim is incurred or after an additional forty-five (45) day
29	period provided under subsection (c):
30	(1) sections 6 and 7 of this chapter do not apply to the
31	processing of the claim; and
32	(2) unless a longer period is provided for by contract, the
33	administrator may refuse to process the claim.
34	SECTION 6. IC 5-10-8.1-5.8 IS ADDED TO THE INDIANA
35	CODE AS A NEW SECTION TO READ AS FOLLOWS
36	[EFFECTIVE JULY 1, 2005]: Sec. 5.8. (a) Except as provided in
37	subsection (b), a provider shall not bill a covered individual for any
38	amount of a claim not paid by an administrator because the
39	administrator is:
40	(1) relieved of responsibility for payment; or
41	(2) permitted to take a deduction from any amount owed;



to the provider under this chapter.

1	(b) A provider may bill a covered individual for:
2	(1) a copayment or deductible; or
3	(2) an amount billed for health care services that are not
4	covered under the health benefit plan.
5	(c) A provider that violates subsection (a) is subject to sanction
6	by the provider's licensing authority as follows:
7	(1) The licensing authority shall automatically suspend the
8	provider's license for at least:
9	(A) two (2) months for the first violation;
10	(B) six (6) months for the second violation; and
11	(C) one (1) year for the third violation.
12	(2) The licensing authority shall automatically revoke the
13	provider's license for at least one (1) calendar year for the
14	fourth or subsequent violation.
15	SECTION 7. IC 5-10-8.1-5.9 IS ADDED TO THE INDIANA
16	CODE AS A NEW SECTION TO READ AS FOLLOWS
17	[EFFECTIVE JULY 1, 2005]: Sec. 5.9. (a) An administrator may
18	deny a duplicate claim.
19	(b) A provider that submits a duplicate claim shall reimburse
20	the administrator the administrator's actual cost of discovering,
21	determining, and denying the duplicate claim.
22	(c) An administrator may terminate any payment agreement
23	entered into with a provider if the provider establishes a pattern of
24	failure with at least ten (10) documented failures to submit claims
25	as required under this chapter.
26	(d) An administrator that terminates an agreement with a
27	provider under subsection (c) shall maintain documentation
28	justifying the termination for review by the department of
29	insurance.
30	SECTION 8. IC 5-10-8.1-6 IS AMENDED TO READ AS
31	FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 6. (a) The administrator
32	shall pay or deny each clean claim in accordance with section 7 of this
33	chapter.
34	(b) An administrator shall notify a provider of any deficiencies in a
35	submitted claim not more than
36	(1) thirty (30) days for a claim that is filed electronically; or
37	(2) forty-five (45) days for a after the claim that is filed on paper;
38	received by the administrator and describe any remedy, including
39	supporting documentation, necessary to establish a clean claim.
40	(c) Failure of an administrator to notify a provider as required under
41	subsection (b) establishes the submitted claim as a clean claim.
42	SECTION 9. IC 5-10-8.1-7 IS AMENDED TO READ AS



1	FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 7. (a) The administrator	
2	shall pay or deny each clean claim as follows:	
3	(1) If the claim is filed electronically, not more than thirty (30)	
4	days after the date the claim is received by the administrator.	
5	(2) If the claim is filed on paper, not more than forty-five (45)	
6	days after the date the claim is received by the administrator.	
7	(b) If:	
8	(1) the administrator fails to pay or deny a clean claim in the time	
9	required under subsection (a); and	
10	(2) the administrator subsequently pays the claim;	
11	the administrator shall pay the provider that submitted the claim	
12	interest on the health benefit plan allowable amount of the claim paid	
13	under this section.	
14	(c) Interest paid under subsection (b):	
15	(1) accrues beginning	
16	(A) thirty-one (31) days after the date the claim is filed under	
17	subsection (a)(1); or	,
18	(B) forty-six (46) days after the date the claim is filed under	
19	subsection $\frac{(a)(2)}{(a)}$; and	
20	(2) stops accruing on the date the claim is paid.	
21	(d) In paying interest under subsection (b), the administrator shall	
22	use the same interest rate as provided in IC 12-15-21-3(7)(A).	
23	SECTION 10. IC 5-10-8.1-9 IS ADDED TO THE INDIANA CODE	
24	AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY	
25	1, 2005]: Sec. 9. (a) If an administrator has a reasonable basis on	
26	which to believe that a claim submitted for payment:	
27	(1) is false;	'
28	(2) falsely represents that a health care service for which the	
29	claim is submitted is medically necessary according to	1
30	professionally accepted standards; or	
31	(3) contains false statements or representations of a material	
32	fact;	
33	the claim may remain pending and the administrator is exempt	
34 35	from the requirements of sections 6 and 7 of this chapter for a	
35 36	reasonable period to allow the administrator to investigate the claim.	
30 37	(b) If, upon completion of an investigation described in	
38	subsection (a), the administrator determines that the claim is valid,	
30 39	the administrator shall pay or deny the claim according to the	
39 40	requirements of sections 6 and 7 of this chapter.	
41	SECTION 11. IC 5-10-8.1-10 IS ADDED TO THE INDIANA	
42	CODE AS A NEW SECTION TO READ AS FOLLOWS	
⊤ ∠	CODE AS A NEW SECTION TO READ AS FOLLOWS	



[EFFECTIVE JULY 1, 2005]: Sec. 10. If a provider submits to an administrator a duplicate claim, a claim that the administrator is unable to process, or a paper claim, the administrator may charge the provider an amount not to exceed one hundred dollars (\$100). The amount charged may be recovered by a reduction of any amount owed by the administrator to the provider.

SECTION 12. IC 5-10-8.1-11 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 11.** If an administrator determines that particular supporting documentation is routinely necessary to process a claim for a particular health care service, the administrator shall establish a standard description of the particular supporting documentation and make the standard description available to providers in an electronic format.

SECTION 13. IC 27-8-5.7-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 2. (a) As used in this chapter, "clean claim" means a claim submitted by a provider for payment under an accident and sickness insurance policy issued in Indiana that has no defect or impropriety, including a lack of supporting documentation, or particular circumstance requiring special treatment preventing payment.

- (b) The term does not include a:
 - (1) duplicate claim; or
 - (2) claim that:

- (A) is submitted more than forty (40) days after the date of service: or
- (B) does not comply with the electronic transaction standards and code sets governing the exchange of health information under the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d).

SECTION 14. IC 27-8-5.7-2.2 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 2.2. As used in this chapter, "duplicate claim" means a duplicate of an original claim when the duplicate is filed less than thirty (30) days after the filing of the original claim.

SECTION 15. IC 27-8-5.7-2.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 2.8.** As used in this chapter, "insured" means an individual entitled to coverage under an accident and sickness insurance policy.

SECTION 16. IC 27-8-5.7-4.3 IS ADDED TO THE INDIANA









y

1	CODE AS A NEW SECTION TO READ AS FOLLOWS
2	[EFFECTIVE JULY 1, 2005]: Sec. 4.3. As used in this chapter,
3	"supporting documentation" includes:
4	(1) verification of employer and insured coverage under an
5	accident and sickness insurance policy;
6	(2) confirmation of premium payment;
7	(3) medical information concerning the insured and health
8	care services provided;
9	(4) information concerning:
10	(A) the responsibility of another third party payor to make
11	payment; or
12	(B) confirmation of the amount paid by another third
13	party payor; or
14	(5) information related to a diagnosis, a treatment, or the
15	provider's identification.
16	SECTION 17. IC 27-8-5.7-4.5 IS ADDED TO THE INDIANA
17	CODE AS A NEW SECTION TO READ AS FOLLOWS
18	[EFFECTIVE JULY 1, 2005]: Sec. 4.5. (a) An insurer and a provider
19	shall, in connection with all claims, use the medical data code sets
20	adopted by the United States Secretary of Health and Human
21	Services under the federal Health Insurance Portability and
22	Accountability Act of 1996 (42 U.S.C. 1320d).
23	(b) An insurer shall comply with the federal regulations
24	promulgated under sections 503 and 505 of the federal Employee
25	Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.) in
26	paying a claim submitted by a provider for payment under an
27	accident and sickness insurance policy.
28	(c) An insurer is not required to pay, and this chapter does not
29	apply to, a claim that is not filed in compliance with the requirements for electronic transaction standards and code sets
30 31	that govern the exchange of health information under the federal
32	Health Insurance Portability and Accountability Act of 1996 (42
33	U.S.C. 1320d).
34	SECTION 18. IC 27-8-5.7-4.6 IS ADDED TO THE INDIANA
35	CODE AS A NEW SECTION TO READ AS FOLLOWS
36	[EFFECTIVE JULY 1, 2005]: Sec. 4.6. (a) A provider shall submit
37	a claim for payment under an accident and sickness insurance
38	policy to the insurer:
39	(1) not more than forty-five (45) days after the date the claim
40	was incurred, or according to the contractual terms agreed to
41	between the insurer and provider; and
42	(2) according to the requirements for the electronic



1	transaction standards and code sets governing the exchange
2	of health information under the federal Health Insurance
3	Portability and Accountability Act of 1996 (42 U.S.C. 1320d).
4	(b) If an insurer requires supporting documentation to process
5	a claim, the provider shall submit the supporting documentation
6	not more than fifteen (15) days after receiving notice that the
7	supporting documentation is required.
8	(c) A provider may submit a written request for additional time
9	to submit a claim not more than forty-five (45) days after the claim
10	is incurred. An insurer that receives a request under this
11	subsection shall provide an additional forty-five (45) day period for
12	the provider to submit the claim.
13	(d) If a provider submits a claim more than:
14	(1) forty-five (45) days and less than fifty-five (55) days after
15	the claim is incurred and has not requested additional time
16	under subsection (c), the insurer may deduct one-tenth $(1/10)$
17	of the total cost of the claim from the payment to the provider
18	for every day that the provider fails to submit the claim after
19	the period specified in subsection (a); or
20	(2) fifty-five (55) days after the date the claim is incurred, the
21	insurer may refuse to pay the claim.
22	(e) If a provider submits a claim more than forty-five (45) days
23	after the claim is incurred or after an additional forty-five (45) day
24	period provided under subsection (c):
25	(1) sections 5 and 6 of this chapter do not apply to the
26	processing of the claim; and
27	(2) unless a longer period is provided for by contract, the
28	insurer may refuse to process the claim.
29	SECTION 19. IC 27-8-5.7-4.7 IS ADDED TO THE INDIANA
30	CODE AS A NEW SECTION TO READ AS FOLLOWS
31	[EFFECTIVE JULY 1, 2005]: Sec. 4.7. (a) Except as provided in
32	subsection (b), a provider shall not bill an insured for any amount
33	of a claim not paid by an insurer because the insurer is:
34	(1) relieved of responsibility for payment; or
35	(2) permitted to take a deduction from any amount owed;
36	to the provider under this chapter.
37	(b) A provider may bill an insured for:
38	(1) a copayment or deductible; or
39	(2) an amount billed for health care services that are not
40	covered under the accident and sickness insurance policy.
41	(c) A provider that violates subsection (a) is subject to sanction
42	by the provider's licensing authority as follows:



(1) The licensing authority shall automatically suspend the
provider's license for at least:
(A) two (2) months for the first violation;
(B) six (6) months for the second violation; and
(C) one (1) year for the third violation.
(2) The licensing authority shall automatically revoke the
provider's license for at least one (1) calendar year for the
fourth or subsequent violation.
SECTION 20. IC 27-8-5.7-4.8 IS ADDED TO THE INDIANA
CODE AS A NEW SECTION TO READ AS FOLLOWS
[EFFECTIVE JULY 1, 2005]: Sec. 4.8. (a) An insurer may deny a
duplicate claim.
(b) A provider that submits a duplicate claim shall reimburse
the insurer the insurer's actual cost of discovering, determining,
and denying the duplicate claim.
(c) An insurer may terminate an agreement entered into with a
provider under IC 27-8-11-3 if the provider establishes a pattern
of failure with at least ten (10) documented failures to submit
claims as required under this chapter.
(d) An insurer that terminates an agreement with a provider
under subsection (c) shall maintain documentation justifying the
termination for review by the department.
SECTION 21. IC 27-8-5.7-5 IS AMENDED TO READ AS
FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 5. (a) An insurer shall
pay or deny each clean claim in accordance with section 6 of this
chapter.
(b) An insurer shall notify a provider of any deficiencies in a
submitted claim not more than
(1) thirty (30) days for a claim that is filed electronically; or
(2) forty-five (45) days for a after the claim that is filed on paper;
received by the insurer and describe any remedy, including
supporting documentation, necessary to establish a clean claim.
(c) Failure of an insurer to notify a provider as required under
subsection (b) establishes the submitted claim as a clean claim.
SECTION 22. IC 27-8-5.7-6 IS AMENDED TO READ AS
FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 6. (a) An insurer shall
pay or deny each clean claim as follows:
(1) If the claim is filed electronically, within thirty (30) days after
the date the claim is received by the insurer.
(2) If the claim is filed on paper, within not more than forty-five
(45) days after the date the claim is received by the insurer.
(b) If:



1	(1) an insurer fails to pay or deny a clean claim in the time
2	required under subsection (a); and
3	(2) the insurer subsequently pays the claim;
4	the insurer shall pay the provider that submitted the claim interest on
5	the accident and sickness insurance policy allowable amount of the
6	claim paid under this section.
7	(c) Interest paid under subsection (b):
8	(1) accrues beginning
9	(A) thirty-one (31) days after the date the claim is filed under
10	subsection (a)(1); or
11	(B) forty-six (46) days after the date the claim is filed under
12	subsection $\frac{(a)(2)}{(a)}$; and
13	(2) stops accruing on the date the claim is paid.
14	(d) In paying interest under subsection (b), an insurer shall use the
15	same interest rate as provided in IC 12-15-21-3(7)(A).
16	SECTION 23. IC 27-8-5.7-8 IS AMENDED TO READ AS
17	FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 8. (a) The
18	commissioner may require an insurer to submit reports concerning
19	the insurer's compliance with sections 5 and 6 of this chapter. If
20	reports are required, the commissioner shall prescribe the content,
21	format, and frequency of the reports in consultation with insurers.
22	The commissioner may not require reports to be submitted more
23	frequently than quarterly.
24	(b) The commissioner may not use findings from a report
25	submitted under subsection (a) as the basis of a finding of a
26	violation of section 5 or 6 of this chapter. The commissioner may
27	use information contained in a report to form the basis for
28	conducting an examination of the insurer. During this examination,
29	the commissioner may examine data collected for the same period
30	as the period covered by the reports, and the commissioner's
31	examination findings may be used as the basis for a finding of a
32	violation of section 5 or 6 of this chapter.
33	(a) (c) If, after completion of an examination under subsection
34	(b), the commissioner finds that an insurer has failed during any
35	calendar year to process and pay clean claims in compliance with this
36	chapter, the commissioner may assess, with reasonable written notice
37	to the insurer of the basis of the commissioner's findings, the
38	penalty to be imposed, and the opportunity for a hearing as
39	described in subsection (e), an aggregate civil penalty against the
40	insurer according to the following schedule:
41	(1) If the insurer has paid at least eighty-five percent (85%) but

less than ninety-five percent (95%) of all clean claims received



42

1	from all providers during the calendar year in compliance with
2	this chapter, a civil penalty of up to ten thousand dollars
3	(\$10,000).
4	(2) If the insurer has paid at least sixty percent (60%) but less
5	than eighty-five percent (85%) of all clean claims received from
6	all providers during the calendar year in compliance with this
7	chapter, a civil penalty of at least ten thousand dollars (\$10,000)
8	but not more than one hundred thousand dollars (\$100,000).
9	(3) If the insurer has paid less than sixty percent (60%) of all
10	clean claims received from all providers during the calendar year
11	in compliance with this chapter, a civil penalty of at least one
12	hundred thousand dollars (\$100,000) but not more than two
13	hundred thousand dollars (\$200,000).
14	(b) (d) In determining the amount of a civil penalty under this
15	section, the commissioner shall consider whether the:
16	(1) insurer's failure to achieve the standards established by
17	sections 5 and 6 of this chapter is due to circumstances beyond
18	the insurer's control; and
19	(2) insurer has been in the business of processing claims for
20	two (2) years or less.
21	(c) (e) An insurer may contest a civil penalty imposed under this
22	section by requesting an administrative hearing under IC 4-21.5 not
23	more than thirty (30) days after the insurer receives notice of the
24	assessment of the fine.
25 26	(d) (f) If the commissioner imposes a civil penalty under this
	section, the commissioner may not impose a penalty against the insurer
27 28	under IC 27-4-1 for the same activity. (e) (g) Civil penalties collected under this section shall be deposited
20 29	in the state general fund.
30	SECTION 24. IC 27-8-5.7-11 IS ADDED TO THE INDIANA
31	CODE AS A NEW SECTION TO READ AS FOLLOWS
32	[EFFECTIVE JULY 1, 2005]: Sec. 11. (a) If an insurer has a
33	reasonable basis on which to believe that a claim submitted for
34	payment:
35	(1) is false;
36	(2) falsely represents that a health care service for which the
37	claim is submitted is medically necessary according to
38	professionally accepted standards; or
39	(3) contains false statements or representations of a material
40	fact;
41	the claim may remain pending and the insurer is exempt from the
12	requirements of sections 5 and 6 of this chapter for a reasonable
_	1



1	period to allow the insurer to investigate the claim.
2	(b) If, upon completion of an investigation described in
3	subsection (a), the insurer determines that the claim is valid, the
4	insurer shall pay or deny the claim according to the requirements
5	of sections 5 and 6 of this chapter.
6	SECTION 25. IC 27-8-5.7-12 IS ADDED TO THE INDIANA
7	CODE AS A NEW SECTION TO READ AS FOLLOWS
8	[EFFECTIVE JULY 1, 2005]: Sec. 12. If a provider submits to an
9	insurer a duplicate claim, a claim that the insurer is unable to
10	process, or a paper claim, the insurer may charge the provider an
11	amount not to exceed one hundred dollars (\$100). The amount
12	charged may be recovered by a reduction of any amount owed by
13	the insurer to the provider.
14	SECTION 26. IC 27-8-5.7-13 IS ADDED TO THE INDIANA
15	CODE AS A NEW SECTION TO READ AS FOLLOWS
16	[EFFECTIVE JULY 1, 2005]: Sec. 13. If an insurer determines that
17	particular supporting documentation is routinely necessary to
18	process a claim for a particular health care service, the insurer
19	shall establish a standard description of the particular supporting
20	documentation and make the standard description available to
21	providers in an electronic format.
22	SECTION 27. IC 27-8-22.1-5 IS AMENDED TO READ AS
23	FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 5. (a) This section
24	applies to an insurer to which IC 27-8-5.7-4.5(a) does not apply.
25	(a) (b) Not more than ninety (90) days after the effective date of a
26	diagnostic or procedure code described in this subsection:
27	(1) an insurer shall begin using the most current version of the:
28	(A) current procedural terminology (CPT);
29	(B) international classification of diseases (ICD);
30	(C) American Psychiatric Association's Diagnostic and
31	Statistical Manual of Mental Disorders (DSM);
32	(D) current dental terminology (CDT);
33	(E) Healthcare common procedure coding system (HCPCS);
34	and
35	(F) third party administrator (TPA);
36	codes under which the insurer pays claims for services provided
37	under an accident and sickness insurance policy or a worker's
38	compensation policy; and
39	(2) a provider shall begin using the most current version of the:
40	(A) current procedural terminology (CPT);
41	(B) international classification of diseases (ICD);
42	(C) American Psychiatric Association's Diagnostic and



1	Statistical Manual of Mental Disorders (DSM);	
2	(D) current dental terminology (CDT);	
3	(E) Healthcare common procedure coding system (HCPCS);	
4	and	
5	(F) third party administrator (TPA);	
6	codes under which the provider submits claims for payment for	
7	services provided under an accident and sickness insurance policy	
8	or a worker's compensation policy.	
9	(b) (c) If a provider provides services that are covered under an	
0	accident and sickness insurance policy or a worker's compensation	1
1	policy:	
2	(1) after the effective date of the most current version of a	1
3	diagnostic or procedure code described in subsection (a); (b); and	
4	(2) before the insurer begins using the most current version of the	
5	diagnostic or procedure code;	
6	the insurer shall reimburse the provider under the version of the	4
7	diagnostic or procedure code that was in effect on the date that the	┫
8	services were provided.	
9	SECTION 28. IC 27-13-36.2-1 IS AMENDED TO READ AS	
20	FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 1. (a) As used in this	
21	chapter, "clean claim" means a claim submitted by a provider for	
22	payment for health care services provided to an enrollee that has no	
23	defect or impropriety, including a lack of supporting documentation,	
24	or particular circumstance requiring special treatment preventing	
25	payment.	
26	(b) The term does not include a:	
27	(1) duplicate claim; or	٦
28	(2) claim that:	1
29	(A) is submitted more than forty (40) days after the date of	
0	service; or	
51	(B) does not comply with the electronic transaction	
32	standards and code sets governing the exchange of health	
3	information under the federal Health Insurance Portability	
34	and Accountability Act of 1996 (42 U.S.C. 1320d).	
55	SECTION 29. IC 27-13-36.2-1.5 IS ADDED TO THE INDIANA	
66	CODE AS A NEW SECTION TO READ AS FOLLOWS	
57	[EFFECTIVE JULY 1, 2005]: Sec. 1.5. As used in this chapter,	
8	"duplicate claim" means a duplicate of an original claim when the	
39	duplicate is filed less than thirty (30) days after the filing of the	
10	original claim.	
1	SECTION 30. IC 27-13-36.2-2.3 IS ADDED TO THE INDIANA	
12	CODE AS A NEW SECTION TO READ AS FOLLOWS	



1	[EFFECTIVE JULY 1, 2005]: Sec. 2.3. As used in this chapter,	
2	"supporting documentation" includes:	
3	(1) verification of employer and enrollee coverage under an	
4	individual contract or a group contract;	
5	(2) confirmation of premium payment;	
6	(3) medical information concerning the enrollee and health	
7	care services provided;	
8	(4) information concerning:	
9	(A) the responsibility of another third party payor to make	
0	payment; or	
.1	(B) confirmation of the amount paid by another third	
2	party payor; or	
.3	(5) information related to a diagnosis, a treatment, or the	
4	provider's identification.	
.5	SECTION 31. IC 27-13-36.2-2.5 IS ADDED TO THE INDIANA	
6	CODE AS A NEW SECTION TO READ AS FOLLOWS	
7	[EFFECTIVE JULY 1, 2005]: Sec. 2.5 (a) A health maintenance	U
8	organization and a provider shall, in connection with all claims, use	
9	the medical data code sets adopted by the United States Secretary	
20	of Health and Human Services under the federal Health Insurance	
21	Portability and Accountability Act of 1996 (42 U.S.C. 1320d).	
22	(b) A health maintenance organization shall comply with the	
23	federal regulations promulgated under sections 503 and 505 of the	
24	federal Employee Retirement Income Security Act of 1974 (29	
25	U.S.C. 1001 et seq.) in paying a claim submitted by a provider for	
26	payment under an individual contract or a group contract.	
27	(c) A health maintenance organization is not required to pay,	
28	and this chapter does not apply to, a claim that is not filed in	V
29	compliance with the requirements for electronic transaction	
0	standards and code sets that govern the exchange of health	
31	information under the federal Health Insurance Portability and	
32	Accountability Act of 1996 (42 U.S.C. 1320d).	
33	SECTION 32. IC 27-13-36.2-2.6 IS ADDED TO THE INDIANA	
34	CODE AS A NEW SECTION TO READ AS FOLLOWS	
55	[EFFECTIVE JULY 1, 2005]: Sec. 2.6. (a) A provider shall submit	
6	a claim for payment under an individual contract or a group	
37	contract to the health maintenance organization:	
8	(1) not more than forty-five (45) days after the date the claim	
9	was incurred, or according to the contractual terms agreed to	
10	between the health maintenance organization and provider;	
1	and	
12	(2) according to the requirements for the electronic	



1	transaction standards and code sets governing the exchange
2	of health information under the federal Health Insurance
3	Portability and Accountability Act of 1996 (42 U.S.C. 1320d).
4	(b) If a health maintenance organization requires supporting
5	documentation to process a claim, the provider shall submit the
6	supporting documentation not more than fifteen (15) days after
7	receiving notice that the supporting documentation is required.
8	(c) A provider may submit a written request for additional time
9	to submit a claim not more than forty-five (45) days after the claim
0	is incurred. A health maintenance organization that receives a
1	request under this subsection shall provide an additional forty-five
2	(45) day period for the provider to submit the claim.
3	(d) If a provider submits a claim more than:
4	(1) forty-five (45) days and less than fifty-five (55) days after
5	the claim is incurred and has not requested additional time
6	under subsection (c), the health maintenance organization
7	may deduct one-tenth $(1/10)$ of the total cost of the claim from
8	the payment to the provider for every day that the provider
9	fails to submit the claim after the period specified in
0	subsection (a); or
1	(2) fifty-five (55) days after the date the claim is incurred, the
2	health maintenance organization may refuse to pay the claim.
3	(e) If a provider submits a claim more than forty-five days after
4	the claim is incurred or after an additional forty-five (45) day
5	period provided under subsection (c):
6	(1) sections 3 and 4 of this chapter do not apply to the
7	processing of the claim; and
8	(2) unless a longer period is provided for by contract, the
9	health maintenance organization may refuse to process the
0	claim.
1	SECTION 33. IC 27-13-36.2-2.7 IS ADDED TO THE INDIANA
2	CODE AS A NEW SECTION TO READ AS FOLLOWS
3	[EFFECTIVE JULY 1, 2005]: Sec. 2.7. (a) Except as provided in
4	subsection (b), a provider shall not bill an enrollee for any amount
5	of a claim not paid by a health maintenance organization because
6	the health maintenance organization is:
7	(1) relieved of responsibility for payment; or
8	(2) permitted to take a deduction from any amount owed;
9	to the provider under this chapter.
10	(b) A provider may bill an enrollee for:
1	(1) a copayment or deductible; or
12	(2) an amount billed for health care services that are not



1	covered under the individual contract or group contract.
2	(c) A provider that violates subsection (a) is subject to sanction
3	by the provider's licensing authority as follows:
4	(1) The licensing authority shall automatically suspend the
5	provider's license for at least:
6	(A) two (2) months for the first violation;
7	(B) six (6) months for the second violation; and
3	(C) one (1) year for the third violation.
9	(2) The licensing authority shall automatically revoke the
)	provider's license for at least one (1) calendar year for the
, [fourth or subsequent violation.
2	SECTION 34. IC 27-13-36.2-2.8 IS ADDED TO THE INDIANA
	CODE AS A NEW SECTION TO READ AS FOLLOWS
	[EFFECTIVE JULY 1, 2005]: Sec. 2.8. (a) A health maintenance
	organization may deny a duplicate claim.
	(b) A provider that submits a duplicate claim shall reimburse
	the health maintenance organization the health maintenance
	organization's actual cost of discovering, determining, and denying
	the duplicate claim.
	(c) A health maintenance organization may terminate a
	participating provider's participating provider agreement if the
	participating provider establishes a pattern of failure with at least
	ten (10) documented failures to submit claims as required under
	this chapter.
	(d) A health maintenance organization that terminates an
	agreement with a participating provider under subsection (c) shall
	maintain documentation justifying the termination for review by
	the department.
	SECTION 35. IC 27-13-36.2-3 IS AMENDED TO READ AS
	FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 3. (a) A health
	maintenance organization shall pay or deny each clean claim in
	accordance with section 4 of this chapter.
	(b) A health maintenance organization shall notify a provider of any
	deficiencies in a submitted claim not more than
	(1) thirty (30) days for a claim that is filed electronically; or
	(2) forty-five (45) days for after a claim that is filed on paper;
	received by the health maintenance organization and describe any
	remedy, including supporting documentation, necessary to establish
	a clean claim.
)	(c) Failure of a health maintenance organization to notify a provider
	as required under subsection (b) establishes the submitted claim as a
	clean claim.
	Cicuii Ciuiiii.



1 2	SECTION 36. IC 27-13-36.2-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 4. (a) A health
3	maintenance organization shall pay or deny each clean claim as
4	follows:
5	(1) If the claim is filed electronically, not more than thirty (30)
6	days after the date the claim is received by the health maintenance
7	organization.
8	(2) If the claim is filed on paper, not more than forty-five (45)
9	days after the date the claim is received by the health maintenance
10	organization.
11	(b) If:
12	(1) a health maintenance organization fails to pay or deny a clean
13	claim in the time required under subsection (a); and
14	(2) the health maintenance organization subsequently pays the
15	claim;
16	the health maintenance organization shall pay the provider that
17	submitted the claim interest on the lesser of the usual, customary, and
18	reasonable charge for the health care services provided to the enrollee
19	or an amount agreed to between the health maintenance organization
20	and the provider paid under this section.
21	(c) Interest paid under subsection (b):
22	(1) accrues beginning
23	(A) thirty-one (31) days after the date the claim is filed under
24	subsection (a)(1); or
25	(B) forty-six (46) days after the date the claim is filed under
26	subsection $\frac{(a)(2)}{(a)}$; and
27	(2) stops accruing on the date the claim is paid.
28	(d) In paying interest under subsection (b), a health maintenance
29	organization shall use the same interest rate as provided in
30	IC 12-15-21-3(7)(A).
31	SECTION 37. IC 27-13-36.2-6 IS AMENDED TO READ AS
32	FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 6. (a) The
33	commissioner may require a health maintenance organization to
34	submit reports concerning the health maintenance organization's
35	compliance with sections 3 and 4 of this chapter. If reports are
36	required, the commissioner shall prescribe the content, format, and
37	frequency of the reports in consultation with health maintenance
38	organizations. The commissioner may not require reports to be
39	submitted more frequently than quarterly.
40	(b) The commissioner may not use findings from a report
41	submitted under subsection (a) as the basis of a finding of a
12	violation of section 3 or 4 of this chapter. The commissioner may



	10
1	use information contained in a report to form the basis for
2	conducting an examination of the health maintenance organization.
3	During this examination, the commissioner may examine data
4	collected for the same period as the period covered by the reports,
5	and the commissioner's examination findings may be used as the
6	basis for a finding of a violation of section 3 or 4 of this chapter.
7	(a) (c) If, after completion of an examination under subsection
8	(b), the commissioner finds that a health maintenance organization has
9	failed during any calendar year to process and pay clean claims in
10	compliance with this chapter, the commissioner may assess, with
11	reasonable written notice to the health maintenance organization
12	of the basis of the commissioner's findings, the penalty to be
13	imposed, and the opportunity for a hearing as described in
14	subsection (e), an aggregate civil penalty against the health
15	maintenance organization according to the following schedule:
16	(1) If the health maintenance organization has paid at least
17	eighty-five percent (85%) but less than ninety-five percent (95%)
18	of all clean claims received from all providers during the calendar
19	year in compliance with this chapter, a civil penalty of up to ten
20	thousand dollars (\$10,000).
21	(2) If the health maintenance organization has paid at least sixty
22	percent (60%) but less than eighty-five percent (85%) of all clean
23	claims received from all providers during the calendar year in
24	compliance with this chapter, a civil penalty of at least ten
25	thousand dollars (\$10,000) but not more than one hundred
26	thousand dollars (\$100,000).
27	(3) If the health maintenance organization has paid less than sixty
28	percent (60%) of all clean claims received from all providers
29	during the calendar year in compliance with this chapter, a civil
30	penalty of at least one hundred thousand dollars (\$100,000) but
31	not more than two hundred thousand dollars (\$200,000).
32	(b) (d) In determining the amount of a civil penalty under this
33	section, the commissioner shall consider whether the:
34	(1) health maintenance organization's failure to achieve the
35	standards established by sections 3 and 4 of this chapter is due to
36	circumstances beyond the health maintenance organization's
37	control; and
38	(2) health maintenance organization has been in the business
39	of processing claims for two (2) years or less.
40	(e) A health maintenance organization may contest a civil

penalty imposed under this section by requesting an administrative hearing under IC 4-21.5 not more than thirty (30) days after the health



1	maintenance organization receives notice of the assessment of the fine.	
2	(d) (f) If the commissioner imposes a civil penalty under this	
3	section, the commissioner may not impose a penalty against the health	
4	maintenance organization under IC 27-4-1 for the same activity.	
5	(e) (g) Civil penalties collected under this section shall be deposited	
6	in the state general fund.	
7	SECTION 38. IC 27-13-36.2-9 IS ADDED TO THE INDIANA	
8	CODE AS A NEW SECTION TO READ AS FOLLOWS	
9	[EFFECTIVE JULY 1, 2005]: Sec. 9. (a) If a health maintenance	
10	organization has a reasonable basis on which to believe that a	- 1
11	claim submitted for payment:	
12	(1) is false;	
13	(2) falsely represents that a health care service for which the	
14	claim is submitted is medically necessary according to	
15	professionally accepted standards; or	
16	(3) contains false statements or representations of a material	1
17	fact;	
18	the claim may remain pending and the health maintenance	
19	organization is exempt from the requirements of sections 3 and 4	
20	of this chapter for a reasonable period to allow the health	
21	maintenance organization to investigate the claim.	ı
22	(b) If, upon completion of an investigation described in	
23	subsection (a), the health maintenance organization determines	
24	that the claim is valid, the health maintenance organization shall	
25	pay or deny the claim according to the requirements of sections 3	
26	and 4 of this chapter.	_
27	SECTION 39. IC 27-13-36.2-10 IS ADDED TO THE INDIANA	1
28	CODE AS A NEW SECTION TO READ AS FOLLOWS	
29	[EFFECTIVE JULY 1, 2005]: Sec. 10. If a provider submits to a	1
30	health maintenance organization a duplicate claim, a claim that the	
31	health maintenance organization is unable to process, or a paper	
32	claim, the health maintenance organization may charge the	
33	provider an amount not to exceed one hundred dollars (\$100). The	
34	amount charged may be recovered by a reduction of any amount	
35	owed by the health maintenance organization to the provider.	
36	SECTION 40. IC 27-13-36.2-11 IS ADDED TO THE INDIANA	
37	CODE AS A NEW SECTION TO READ AS FOLLOWS	
38	[EFFECTIVE JULY 1, 2005]: Sec. 11. If a health maintenance	
39	organization determines that particular supporting documentation	
40	is routinely necessary to process a claim for a particular health	
41	care service, the health maintenance organization shall establish a	

standard description of the particular supporting documentation



42

electronic format. SECTION 41. IC 27-13-41 IS REPEALED [EFFECTIVE JULY 1, 2005]. SECTION 42. [EFFECTIVE JULY 1, 2005] (a) IC 5-10-8.1, IC 27-8-5.7, and 27-13-36.2, all as amended by this act, apply to claims incurred after June 30, 2005. (b) This SECTION expires July 1, 2007.	1	and make the standard description available to providers in an	
2005]. SECTION 42. [EFFECTIVE JULY 1, 2005] (a) IC 5-10-8.1, IC 27-8-5.7, and 27-13-36.2, all as amended by this act, apply to claims incurred after June 30, 2005.	2	electronic format.	
SECTION 42. [EFFECTIVE JULY 1, 2005] (a) IC 5-10-8.1, IC 27-8-5.7, and 27-13-36.2, all as amended by this act, apply to claims incurred after June 30, 2005.	3	SECTION 41. IC 27-13-41 IS REPEALED [EFFECTIVE JULY 1,	
IC 27-8-5.7, and 27-13-36.2, all as amended by this act, apply to claims incurred after June 30, 2005.	4	2005].	
IC 27-8-5.7, and 27-13-36.2, all as amended by this act, apply to claims incurred after June 30, 2005.	5	SECTION 42. [EFFECTIVE JULY 1, 2005] (a) IC 5-10-8.1,	
claims incurred after June 30, 2005.			
(b) This SECTION expires July 1, 2007.	7		
	8	(b) This SECTION expires July 1, 2007.	
			U



